# Are psychiatrists an endangered species? Observations on internal and external challenges to the profession

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*Based on recently voiced concerns about a crisis in psychiatry, six challenges to our profession are identified and discussed. As we approach the revisions of ICD-10 and DSM-IV, the validity of psychiatry's diagnostic definitions and classification systems is increasingly questioned also from inside psychiatry. In addition, confidence in the results of therapeutic intervention studies is waning. A further challenge is the existence of de facto subgroups with opposing ideologies, a situation which is responsible for an unclear role profile of the psychiatrist. Challenges from outside include mounting patient and carer criticism, intrusion of other professions into psychiatry's traditional field of competence, and psychiatry's low status within medicine and in society in general. Studies suggest that the decline of the recruitment into psychiatry, as it is observed in many countries, might be related to problems arising from these challenges. It is unclear whether psychiatry will survive as a unitary medical discipline or whether those segments which are more rewarding, both financially and in status, will break away, leaving the unattractive tasks to carry out by what remains of psychiatry. The demise of the generalist and the rise of the specialist in modern society may contribute to this development. Attempts are underway by professional bodies to define the profile of a "general psychiatrist". Such discussions should be complemented by an analysis of the incentives which contribute to the centrifugal tendencies in psychiatry.*

**Key words:** Future of psychiatry, diagnosis, treatment, user and carer criticism, professional competition

***(World Psychiatry 2010;9:21-28)***

In the 2009 edition of the New Oxford Textbook of Psychiatry, where the discipline presents itself impressively on more than 2000 pages, P. Pichot, Past President of the WPA and a long-time authority on the history of psychiatry, devotes the last few paragraphs of his chapter "History of psychiatry as a medical specialty" to the discussion of a potential crisis in psychiatry. Psychiatry, as he concludes, is threatened by either being incorporated in other medical specialties or being deprived of its medical character (1). In psychiatric journals, the question is being discussed whether and how psychiatry will "survive into the second half of the 21st century" (2), and the presence of "considerable pessimism and a sense of foreboding among psychiatrists" is being described (3). In many countries, a shortage of psychiatrists is reported (4,5). The question has even been asked whether psychiatry should "exist" (6). And we are being advised by our neurological colleagues to abandon the term "mental illness" and replace it by "brain illness" (7).

What is behind such messages? Are they indicating only personal views or local problems? This is improbable. Why should the WPA have recently launched activities and projects on such topics as stigmatization of psychiatry and psychiatrists, furthering the choice of psychiatry as a career by medical students, and improving the prospect for early careers in psychiatry (8,9)?

So, 200 years after its birth (10), is there something wrong with psychiatry? And, if so, what is it? In order to shed some light on this issue, I have listened around, looked back on my own forty years as a psychiatrist and searched the literature for signs of a crisis, including the literature on professions in general.

Psychiatry as a profession can be looked at with the eyes of the sociology of professions, which analyses the relationship of professions with society at large. In times of crisis, this can usefully supplement the inside views of the professions themselves, which tend to focus on the relationship between a profession and its clients, including the professional value systems defining this relationship (11). From the viewpoint of sociology, professions in general are characterized by: a) ownership of a specialized body of knowledge and skills, which defines the field of competence and the scope of potential clients, including the demarcation from other professions; b) holding a high status in society (both through financial and other rewards); c) being granted autonomy (and thereby power) by society, e.g. in recruiting and excluding members; d) being obliged, in return for the above, to guarantee high quality standards in providing services (being "professional") and following ethical rules (12,13).

I will discuss here six challenges which are related to the first two of the above criteria: three challenges "from inside", basically referring to the decreasing confidence about the knowledge base of psychiatry and to the lack of a coherent theoretical basis; and three "from outside", including client discontent, competition from other professions, and the negative image of psychiatry. There are certainly other challenges – such as increasing state and insurance interventions, asking for improved quality of care despite growing restrictions – but they mostly concern medicine as a whole and will not be discussed here.

## CHALLENGES FROM INSIDE

### Decreasing confidence about the knowledge base: diagnosis and classification

Disease categories and their classification are the pervasive organizing principle for most aspects of medicine, including psychiatry as a medical specialty. Diagnoses are meant to be used

for making therapeutic decisions, for teaching purposes, for reimbursement, for defining patient populations for research, and for statistical returns. In psychiatry we have the confusing situation of two different internationally used diagnostic systems. In any member state of the World Health Organization (WHO), on discharge of a patient from hospital, a diagnosis from chapter V of the International Classification of Diseases (ICD-10) must be selected. However, for psychiatric research to be published in a high impact factor journal, it is advisable to use the Diagnostic and Statistical Manual (DSM-IV) of the American Psychiatric Association (APA).

The parallelism of these two major diagnostic systems exists since nearly 60 years. In 1949, the sixth revision of the International Classification of Diseases (ICD-6, 14) included for the first time mental disorders (earlier versions covered only mortality). Three years later, the APA launched its own classification system (DSM-I, 15). We have now arrived at ICD-10 (1992) and DSM-IV (1994), and the next revisions of the "big two" are due in a few years (DSM-V in 2013; ICD-11 in 2014). There will thus be still two systems in parallel.

Such parallelism is possible because of the very nature of the definitions of most psychiatric diagnoses: they consist of combinations of phenomenological criteria, such as signs and symptoms and their course over time, combined by expert committees in variable ways into categories of mental disorders, which have been defined and redefined again and again over the last half century. The majority of these diagnostic categories are not validated by biological criteria, as most medical diseases are; however, although they are called "disorders", they look like medical diagnoses and pretend to represent medical diseases. In fact, they are embedded in top-down classifications, comparable to the early botanic classifications of plants in the 17th and 18th centuries, when experts decided *a priori* about which classification criterion to use, for instance, whether fruiting bodies or the shape of leaves were the essential criterion for classifying plants (16).

The DSM-III approach of creating "operational definitions" (e.g., "2 out of 5 symptoms" of a list must be present) has certainly rendered the process of arriving at a diagnosis more reliable, in the sense that we can be more sure that, if different psychiatrists assess a patient diagnostically, they will, after evaluating symptoms and other criteria, come more often to the same result. But reliability is different from validity. Psychopathological phenomena certainly exist and can be observed and experienced as such. However, psychiatric diagnoses are arbitrarily defined and do not exist in the same sense as psychopathological phenomena do.

This is not new. However, whereas psychiatric diagnostic classification systems and disease definitions have long been criticized, the character of the attacks has changed. Half a century ago, they came mainly from outside psychiatry (e.g., 17,18). Today, while these assaults continue (19), discussions about the validity of psychiatric diagnoses are also getting momentum within our profession (certainly fuelled by the imminent revisions of the "big two") (20,21). It is no longer just the "usual suspects" who criticize psychiatric diagnosis and classification systems; the discussion has arrived at the heart of our profession.

For instance, psychiatrists talk about the "genetic deconstruction of psychosis" (22), the lack of validity of psychiatric diagnoses despite their utility (23), and the poor diagnostic stability of psychiatric disorders (24). From psychiatric geneticists one hears that they have to use "star war technology on bow and arrow diagnosis". Recently, a prominent psychiatric researcher commented: "It has been suggested that the debate is political. This is not the case however, as solid scientific evidence pointing to the absence of nosological validity of diagnostic categories that nevertheless invariably are subject to paradoxical psychiatric reification, lies at the heart of the argument" (25).

The sociologist A. Abbott has observed that the control that professions have over their body of knowledge allows them to seize new problems and redefine their scope of interest (26). With this perspective in mind, it can be argued that, while some psychiatric disorders have some kind of "clinical validity" (e.g., bipolar disorder), the DSM has "fabricated non-validated psychiatric diagnoses out of the general human predicament" (27). Psychiatry "abandoned the island of psychiatric disease and was thus engulfed in the boundless sea of human troubles", as F. Redlich has put it more than 50 years ago when referring to psychoanalysis (28, quoted in 17). The issue whether we are able to "differentiate between true mental disorders and homeostatic reactions to adverse life events" (29) is more pressing than ever.

All kinds of rescue efforts are under way in relation to these threats to the diagnostic knowledge base of psychiatry, and a plethora of suggestions are being made: to identify "metastructures" (30), to supplement diagnostic categories with dimensional measures (21) or a "cross-diagnostic approach" (31), to use "epistemic iteration" (16), or to provide a "person-centered integrative diagnosis" (32). Recently, a group of psychiatrists has asked for the establishment of a conceptual working group for DSM-V, pointing out that in past DSM revisions conceptual questions were considered only on an *ad-hoc* basis by individual workgroups and the task force (33). Everything seems open.

It has also been proposed to put more emphasis on the clinical utility of diagnosis, such as ease of usage, communication, and treatment planning (34). However, in clinical practice, the selection of medication is only vaguely related to diagnosis (e.g., antidepressants are used across a wide range of conditions) (35), and in community mental health services, diagnoses are mainly used for channelling resources, and different classifications are employed for dealing with clients in everyday work (36).

The threatening bottom line of these discussions is that, if our diagnostic categories have not been valid until now, then research of any type – epidemiological, etiological, pathogenetic, therapeutic, biological, psychological or social – if carried out with these diagnoses as inclusion criterion, is equally invalid.

### Decreasing confidence about the knowledge base: therapeutic interventions

We are living in the era of evidence-based medicine (37). Based on meta-analyses and systematic reviews of carefully selected methodologically sound studies, guidelines for practice are prepared and become prescriptive – we can no longer accept clinical experience alone. But how sure can we really be of our treatment decisions?

When in 2008 a meta-analysis of antidepressant medication studies was published (38), with the main message that in mild and moderate depression antidepressants are no better than placebo, the result went around the world immediately – the special "kick" for the media being that the authors had included in their meta-analysis also those studies which had not been published (but submitted to the US Food and Drug Administration). A related study corroborated these findings (39), leading to some discussion within psychiatry (40). The fact that trials with positive findings are published more often and more quickly than those with negative findings has become a serious concern not only in psychiatry, but in the whole field of medicine (41).

In a different development, the randomized controlled drug trials in schizophrenia had been criticized for their limitations, and "pragmatic" or "real world" trials had been proposed (42). When such real world pragmatic trials were carried out, the superiority of the second over the first generation antipsychotics could not be reproduced (43,44).

It is evident that such results increase uncertainty, even more so because – given the lack of validity of psychiatric diagnoses and the difficulties in obtaining homogeneous samples of patients – they do not imply that the original studies were wrong and the new ones are correct. When attempting to establish evidence-based guidelines for clinical practice, we face an inherent contradiction in the methodology of randomized controlled trials: striving for internal validity leads to highly selected samples, meaning that the results cannot be easily generalized to the real world, while looking for a high representativeness of the study samples generates methodological biases (45,46). It has been suggested in this context to have two parallel assessments of evidence: the usual evidence of efficacy of intervention studies, and "corroborative" evidence assessing the transferability of results into the real world (47,48). A related issue is that polypharmacy and combinations of treatments are common in clinical practice (49), whereas most evidence is available only for monotherapies.

In addition to these problems, the conflicts of interest arising from the relationship between doctors and industry (50) are creating further doubts. "Ghostwriting" has recently received increased attention as a "credibility" issue, in the scientific community (51) as well as in the media and from politicians (52). If we add concerns about psychotherapeutic interventions and their unintended side effects (53,54), we, our patients and the public must get increasingly insecure about the trustworthiness of the proofs that our professional interventions work appropriately.

### Lack of a coherent theoretical basis

"Ask three psychiatrists and you get four answers". I have heard this in many variations from politicians and health administrators, as an excuse for doing nothing, whenever I tried to get them to improve psychiatric care and increase resources. Over-valued beliefs and nostrums are not uncommon in medicine, but perhaps nowhere do so many different ideologies flourish as in psychiatry.

It is a truism that psychiatry is split into many directions and sub-directions of thought. Considering that a common knowledge base is a core defining criterion of any profession, this split is a considerable threat to the coherence of our profession. Textbooks usually cover all aspects (55), and integration is freely advocated, but not pursued in any practical way. There are worldwide associations for biological psychiatry, psychotherapy and social psychiatry which all claim better patient care as their main aim (often with strong relations to or co-operation with neighbouring disciplines and professions). Each approach has its own body of knowledge, conferences and journals. The tone with each other is getting increasingly irritated (56-60), not the least also because of resource implications (61).

After having lived and worked for some time with a specific mind-set, and seeing only restricted groups of patients, it is difficult or impossible to change. This was true also for our forefathers, who developed their concepts in specific settings – for example, E. Kraepelin working mainly with psychotic patients in mental hospitals, and S. Freud working mostly with neurotic ones in private practice, each of them with no or very limited experience of the other setting – and so came up with completely different ideas (62). It is indeed difficult to stay abreast of all aspects of psychiatry, although the professional associations (such as the WPA) regularly organize congresses where all kind of professional knowledge is available.

The danger of splitting or being absorbed by other professions (1) is tellingly illustrated for US psychiatry by the divide between the "two cultures" of biological psychiatry and psychotherapy as described by a neutral scientist from outside (63) and by the mutual stereotypes of "mindless" and "brainless" (64). Guidelines usually stress the combination of both approaches, but reimbursement systems do not favour such integration.

## CHALLENGES FROM OUTSIDE

### Client discontent

While criticism of psychiatry by professionals has been around for a long time (17,18) and still continues today (65), discontent with our profession is been increasingly voiced also by our "clients", the patients. Whereas criticism within a profession can be regarded as contributing to its dynamic development, discontent of clients with a profession may be detrimental.

Over the last few decades, I have

seen several new terms coming up for our patients. First it was "client", then "consumer" (implying that one claims one's right to receive adequate services). Then "user" or "service user" appeared, a term which is difficult to translate from English into many other languages, but seems to be quite common nowadays in the English speaking world, also among professionals and even in government documents. These names in themselves imply a change in the relationship between doctor and patient, with the traditional "asymmetric" paternalistic model being outlived by new, more symmetrical ones (like the "informative", "interpretative" and "deliberate" models) (66). Also, by replacing the word "patient", these terms are indicating a distance to medicine. Finally "ex-user", "ex-patient" and "survivor of psychiatry" came on the scene, indicating complete detachment from psychiatry.

"Discontent" covers a broad spectrum, from the "survivor of psychiatry" concept (67), which implies that psychiatry should not exist *at all*, to other forms of discontent, criticizing psychiatry "*as it is*" (68). Today the Internet allows persons having undergone psychiatric treatment to exchange their experiences. And there are quite a few negative experiences, in addition to positive ones, which are all made public in personal stories worldwide (e.g., 69,70). Topics raised are manifold, and range from diagnosis to pharmacological treatment, from compulsory measures to neglect of quality of life issues. Also family members (in the English speaking world now called "carers") voice discontent with psychiatry, although often from a different perspective than the users.

Self-help organizations on mental health issues are established everywhere, organized by "clients" (71) and by "carers" (72). Such associations have become relevant not only in terms of "empowerment" and "self-confidence" of their members, which is enacted also in conferences and in creating training and consultancy companies (e.g., 73), but also at the political level, where, depending on the cooperation of health politicians and administrators, they can participate in the planning process.

Many user groups and organizations focus today on the concept of recovery (74), which is increasingly advocated as the guiding principle for mental health policy in many English-speaking countries. Some experts claim this is only a "rhetorical consensus" and point to the need of distinguishing "clinical" vs. "personal" recovery"(75), and recovery as "outcome" vs. recovery as "process". Also, misunderstandings arise when the word is translated into other languages.

The focus on clients' needs and inclusion is now supported by documents of international organizations such as the Unites Nations (76), the European Commission (77), the Council of Europe (78), and the WHO (79). The psychiatric profession has also contributed to this perspective: for instance, guidelines for "better mental health care" have been produced, giving equal importance to "ethics", "evidence" and "experience", including the experience of users (80), and the quality of life issue has been taken up (81). But client criticism continues.

## Competition from other professions

As Abbott (26) has observed, professions, in addition to defining their knowledge base and expanding their scope of competence, are watchful against interlopers. In the post-modern era, with its growth of a culture of professional expertise (82), there are more and more "intruders" into the territory which psychiatry claims for itself. And, unwittingly or wittingly, in order to attract patients, they often make use of the stigma associated with being treated by psychiatrists.

On the medical side, it is neurologists, general practitioners and doctors who practice alternative medicine who compete with psychiatrists. For instance, in many countries, the volume of prescription of antidepressants is much larger in general practice than in psychiatry. Neurologists understandably claim organic brain syndromes for themselves, but depending on the reimbursement system they also treat psychiatric patients in many countries.

Psychologists, psychotherapists and clinical social workers constitute further large professional groups who compete with psychiatrists. In Austria there are around 10 times as many officially recognized clinical/health psychologists/psychotherapists as psychiatrists. In the USA, by 1990, 80,000 clinical social workers were active in the psychiatric socio-psychological domain, a quarter of them in private practice (1). Psychologists do not only compete in the psychological and psychotherapeutic sector: in the USA, for instance, according to the APA, since 1995 bills to grant prescribing privileges to psychologists have been considered one hundred times in 23 different states. They have been defeated 96 times, but New Mexico, Louisiana, Wisconsin and Oregon have enacted relevant legislation (83).

There are also more systematic challenges, such as the "Improving Access to Psychological Therapies" programme in England, where 3,600 "psychological therapists" are being trained in cognitive behavioural therapy (84). Also, a government document in England on "New Ways of Working" (85) gives psychiatrists more of a supervising role, while upgrading other professions in the mental health services with regard to direct patient contact. Given the lack of psychiatrists in developing countries, this is exactly proposed for them (86). This proposal creates a dilemma, expressed tellingly by an English psychiatrist as follows: "Psychiatrists must continue to see patients, also in the first line and not just as supervisor. If we, as consultant body, see a small number of cases, while supervising others who are seeing vastly more people than ourselves, it is only a matter of time before we lose respect, credibility and competence" (87).

How do we respond to these developments? How to keep the balance between our own identity and the identity of other professions, in a field where overlap is common and increasing? How can cooperation be organized in a satisfying way? Fundamental issues come up here, such as private enterprise vs. public employment, single handed vs. group practices, responsibility and risk management, as well as hospital vs.

community treatment. Team work warrants special attention (88).

### Negative image

I think of myself as a rather average looking and behaving person. In social contacts with new people outside my professional milieu, it becomes unavoidable after some time to disclose my profession. And I often meet with disbelief: "*You* are a psychiatrist!?". I am not always sure what people mean by this, but I have come to take it as a compliment. What on earth, do they think a psychiatrist looks like and behaves?

Every psychiatrist knows it and has experienced it: there is something special about our profession, in terms of how people view us. The portrayals of psychiatric treatments in films are rarely positive (89) and a number of stereotypes circulate about us, not least in jokes, such as the "nutty professor", the "analyst" and the "aloof interrogator" (68,90). Some of these stereotypes might go back to a time when psychiatrists were still mainly working in large mental hospitals, away from normal life, and it was deemed that by this they become strange persons themselves and not very different from their patients (91).

It has been suggested that such image factors may play a role in the decision of medical students not to choose psychiatry as a specialty (92) or for early drop-out from a psychiatric specialty training career (93): doctors who had started a training career as a psychiatrist in England, but had broken it off, agreed most frequently with the statement that psychiatry had a poor public image and that they were not sufficiently respected by doctors in other disciplines.

Concerning patient contacts with psychiatry, a case vignette-based general population study in Germany found that only a minority of interviewees recommended to see a psychiatrist as the first choice (94). Similar results were reported in Austria and Australia (95). Probably people fear that, after having been in contact with us, they might be stigmatized and discriminated, if this becomes known. There is a considerable desire in the general population for social distance from people with mental disorders (96), and stigma and discrimination are well documented (97). This is known by anyone who develops psychological problems and considers to ask for professional help. Also, people might assume that psychiatrists (in contrast to psychologists and psychotherapists) will treat them mainly with medication, and the majority refuses this: in the Austrian survey, the large majority recommended primarily psychotherapy, even for dementia, where this percentage amounted to 73% (95).

The "stigmatization" of psychiatrists is under-researched (98), if compared to the stigmatization of our patients. There might also be a more complex relationship between these two topics. It has been suggested that the members of the psychiatric profession can simultaneously be stigmatizers, stigma recipients and powerful agents of de-stigmatization (99). With so many open questions, it is understandable that the WPA is currently funding a research project on "stigmatization of psychiatry and psychiatrists" (9).

## WHERE IS PSYCHIATRY GOING AND WHO IS GOING THERE?

According to information received from the WPA Secretariat, there are more than 200,000 certified psychiatrists around the world in WPA's 134 Member Societies. There are regional differences, especially a large divide between developed and developing countries. It is therefore difficult to draw a general picture of a trend for the development of the psychiatric workforce. Factors which influence it are manifold and situations in various countries are very different.

In general, however, a decline of recruitment into the profession seems to take place. And while forecasts in many countries show that the demand for psychiatrists (100), or at least for psychiatric services (101), will grow, above all also in developing countries (86), there are doubts whether we as a profession will be able to meet this demand. The WPA has consequently initiated activities in order to promote the choice of psychiatry as a career by medical students and to make the specialty more attractive by improving the prospect for early careers in psychiatry (8,9).

In the US, the number of medical students choosing psychiatry as a career had been in decline over more than two decades in a study published in 1995 (102). A 2009 report gives a more optimistic picture, but over 30% of psychiatrists in residency training are international medical graduates (101). In England, in 2008, general psychiatrists were on the "national shortage occupation list" of the Migration Advisory Committee (which facilitates international recruitment) and 80% of trainees sitting on the MRCPsych examination were international medical graduates (100). The Royal College of Psychiatrists in the UK sees "recruitment into psychiatry at a crisis point" (103).

In developing countries, there is definitely a shortage of psychiatrists, with for instance only one psychiatrist for 640,000 population in Pakistan (4). A WPA task force has discussed the "brain drain" from developing to industrialized countries (mainly the US, the UK, Canada and Australia) (104). In addition to other motives, it is quite obvious that a shortage of psychiatrists in industrialized countries facilitates this brain drain.

Some reasons for a decline in recruitment may be only of local relevance, such as changes in the training curriculum, long working hours, unpaid extra hours, low salaries or overload with administration. The divide between the public and the private sector, with the latter getting more and more attractive in many countries, might become increasingly important in the future. In Australia, it seems to be the lack of psychiatrists in the public sector which has led to an influx of psychiatrists from Africa, India and China (105). In Germany, a shortage of psychiatrists working in inpatient settings has developed, partly because the Netherlands and Switzerland offer better working conditions (5).

Recruitment into psychiatry is a complex process, depending on attitudes of medical students, the image of psychiatry, the availability of posts, and other

factors (106). One reason for the decline of recruitment into psychiatry, which comes up again and again (92,93,107), is medical students' and early dropouts' negative perception of the field of psychiatry, relating to lack of intellectual challenge, doubts about the effectiveness of psychiatric treatments, poor opinions of peers and faculty about psychiatry, and low prestige of psychiatry within medicine, while fear of violence might also be an issue (108). In a recent study, UK medical graduates who initially chose psychiatry but did not pursue it as a career, reported low status of psychiatry within the medical disciplines, little or no improvement in many patients and the lack of an evidence base for diagnosis and treatment as important reasons for quitting (93). Some argue that recruitment could be improved by giving psychiatry a clearer neuroscientific identity (56,57,109). But it can also be argued that the opposite might be true (59).

Obviously, the identity of a profession and its status within medicine and in society are important recruitment incentives and disincentives – hence the title of this section, "Where is psychiatry going and who is going there?", taken from an article in Academic Medicine (110) relating recruitment into US psychiatry to its changing jurisdictional boundaries and to the ambiguities of its overarching conceptual framework. But where is psychiatry going?

## THE FUTURE OF PSYCHIATRY

Many would argue that our discipline has gained in status by a tremendous increase of knowledge acquired over the past decades. However, there are indications that psychiatry's diagnostic and therapeutic knowledge base is in a credibility crisis and that the coherence of our discipline is threatened by the existence of *de facto* ideological subgroups. In addition, we are increasingly criticized by our patients and their carers (with the Internet offering new possibilities for that purpose); other professions are more and more claiming segments of our field of competence; and our image in society and in medicine is less positive than many of us might think. Thus, for an outside observer, many of the criteria which define a profession are in jeopardy.

Nevertheless, some authors are quite confident that psychiatry will survive. P. Pichot, who considers psychiatry as threatened of "being incorporated in other medical specialties or being deprived of its medical character", concludes – from a long-term historical perspective – that the crisis of psychiatry is "just another transitory episode in its history"(1). And the author of the above mentioned article in Academic Medicine (110), after analysing at length the difficulties psychiatry is experiencing, expresses trust that "art is long, life is short, but psychiatry will surely endure", basing his confidence on the "rich intellectual milieu" and a "controllable life style" which future trainees might be able to expect. But can we just trust in the repetition of history and the potential attractiveness of an intellectual milieu, let alone the promise of a controllable life style (111)?

The conclusion that "art is long, life is short, but psychiatry will surely endure" (110) is followed by a small but decisive postscript showing the author's ambiguity: "It simply isn't clear in what form or with whom that is mostly to occur". There is no doubt that psychiatry offers services which are needed by society. But it is not clear whether it will do this in the future as a single profession (albeit with sub-specialities, e.g., forensic, child and adolescent, geriatric) and in cooperation with other professions, or whether it (or parts of it) will suffer a more or less "hostile takeover" by other professions.

Within psychiatry, partly as a reaction to the challenges discussed above, a process of "cream skimming" can be observed, with substantial subgroups of our profession concentrating on specific, intellectually and financially more rewarding segments and treatments, which often also imply lower stigma, higher status, better career possibilities in academia, and a more controllable life style, thereby leaving to others less rewarding tasks, such as caring for suicidal and violent patients or for those with persistent mental disorders or drug and alcohol dependence. A related general process which furthers the centrifugal tendencies in psychiatry is the demise of the generalist and the rise of the specialist in modern society, with the latter usually having more prestige and financial rewards, but often functioning according to the pattern "I have an answer, do you have a question?" – leaving those who need services without orientation.

If psychiatry is to persist as a profession, it needs to have a conceptual centre. What this might be in the future is not clear. The traditional strengths of psychiatry – clinical experience, a comprehensive knowledge of psychopathology and skills of communication with affected persons – might get lost as a common denominator in today's environment of specialization and it has been suggested that a "renaissance of psychopathology" might be necessary (112). Efforts are underway by professional bodies to define the profile of a psychiatrist in terms of a psychiatric generalist (113,114). It is worthwhile to join such discussions on a larger basis. However, they should be supplemented by a thorough and open analysis about the motives why psychiatrists work in specific contexts and propagate specific approaches, i.e. by an analysis of the incentives and interests behind the visible roles psychiatrists play today in different contexts.

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